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POLICYMAKING UNDER UNCERTAINTY: ROUTINE SCREENING FOR INTIMATE PARTNER VIOLENCE

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Abstract

Intimate partner violence (IPV) is a significant public health issue affecting around 3 million U.S. women during their lifetimes; this paper provides guidance to policymakers on addressing IPV. In 2011, an Institute of Medicine panel recommended routine IPV screening for women and adolescents as part of comprehensive preventive care services, which is in conflict with the 2004 U.S. Preventive Services Task Force recommendations. The current evidence base for policymaking suffers weaknesses related to study design which should be addressed in future research. Meanwhile, policymakers should consider available evidence in their settings, assess local needs, and make recommendations where appropriate.

Keywords

Routine Screening; Intimate Partner Violence; USPSTF Recommendations

PUBLIC HEALTH IMPACT OF INTIMATE PARTNER VIOLENCE

Intimate partner violence (IPV) is the use of physical or sexual violence, threats of physical or sexual violence, or psychological/emotional abuse by an intimate partner (Saltzman 2002). An intimate partner could be a current or former spouse or a current or former non-marital partner (Saltzman, 2002). In the US alone, it is estimated that around three million women are physically abused by their husband or boyfriend per year (The Commonwealth

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ⁱWe use the terms intimate partner violence and domestic violence interchangeably throughout the paper in order to cite sources accurately.

Fund, 1999). The latest data on the prevalence of IPV, collected in 2010 by the National Intimate Partner and Sexual Violence Survey, indicated that over their lifetimes, 24% of American women experience severe physical violence by their intimate partners, 9% experience rape, 17% experience sexual violence other than rape, 11% are stalked, and 48% encounter psychological aggression (Black et al. 2011).

IPV constitutes the primary cause of injury for women between the ages of 16 and 44 in the U.S. (Walby & Allen, 2004). Approximately, 11% to 19% of women encountered in emergency departments, 5.5% to 22.7% of women in primary care settings, and 4% to 15% of those encountered in obstetrics and gynecology practice reported experiencing IPV in the previous year (Gerber et al. 2005). According to the American Medical Association (Flitcraft, 1992, p.39), “Physical and sexual violence is a public health problem that has reached epidemic proportions”. Physicians recognize the importance of this issue as women exposed to IPV experience a wide range of adverse health effects, including but not limited to death, serious injury (e.g., injuries to the head, neck, chest, and abdomen) and chronic medical and mental health problems such as chronic pain, gastrointestinal disorders, hypertension, chest pain, sexually transmitted diseases, depression, post-traumatic stress disorder, and alcohol and drug abuse (Coker et al. 2000; Campbell et al. 2002; Golding, 1999). The direct medical and mental health services costs of these problems (actual dollar expenditures on health care facilities and health professionals) average \$4.1 billion per year, and the indirect costs of lost productivity and wages (including daily values of paid work and household chores for injured victims) amount to \$1.8 billion (Centers for Disease Control and Prevention, 2003). Therefore, health care providers are in a unique position to interrupt the cycle of violence and form part of the solution to this epidemic.

The goal of this paper is to give provide context and justification for the role of state and federal health care policy in addressing IPV, summarize the evidence and recommendations for routine screening to improve detection of IPV, and offer guidance to policymakers who wish to address IPV in their settings.

ROLE FOR HEALTH CARE POLICY

Given the recurrent nature of IPV and because a large percentage of survivors are seen in a wide range of health care settings, policies to address IPV within the health care system have the potential to increase recognition and ensure appropriate referral and treatment of those who suffer IPV. Since the mid-1980s, state policymakers have become more aware of the need for a health care response to IPV. In 1985, domestic violence was designated as a public health issue by U.S. Surgeon General Everett Koop in the Surgeon General’s Workshop on Violence and Public Health (U.S. Department of Health & Human Services, 1986). This workshop brought together 150 advocates, practitioners, educators, and researchers to discuss ways to address this problem in the health care system (U.S. Department of Health & Human Services, 1986).

In 1992, the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), now known as the Joint Commission, mandated as part of its accreditation standards that all medical departments (such as emergency departments and hospital-sponsored ambulatory

care facilities) have in place written protocols and procedures for identifying and intervening in domestic violence cases, including training of medical staff to implement these policies. It was recommended that these health care facilities should also provide a referral list of community resources that offer services for domestic violence victims (JCAHO, 1992).

In 1994, the Violence against Women Act (VAWA) was passed as a part of the Violent Crime Control and Law Enforcement Act (Valente et al. 2001). This act was the first law established at the federal level that established domestic violence as a crime and introduced a civil rights cause of action (Valente et al. 2001). VAWA provides funding for states and local governments to improve law enforcement and prosecution, education and training of judges, and arrest policies. It also funds a National Domestic Violence Hotline and shelters and services for abused women (Valente et al. 2001). However, until recently only a handful of states (Iowa, Maryland, Nevada, Rhode Island, Virginia) have earmarked some funding from VAWA for health care responses to domestic violence (Durborow et al. 2010). The VAWA legislation was reauthorized in 2000 and 2005, and there is a current partisan debate between Republicans and Democrats regarding reauthorization of this legislation in 2012 (Jarrett, 2012). Whereas the VAWA reauthorization bill approved by the Senate includes provisions that add protections to Native American Women, LGBT (lesbian, gay, bisexual, and transgender) victims, and college students, the House bill under consideration leaves out those protections and pares down certain existing protections in the original bill such as those for immigrants (Jarrett, 2012; H.R. 4970). The recent debate highlights the political challenges that policymakers may face in building legislative support for efforts to address IPV and finding an acceptable consensus for specific policies to address this widely-recognized public health issue.

ROUTINE SCREENING AS A POLICY OPTION

Routine screening of women in health care settings is a common policy recommendation for improving detection of IPV (McCord-Duncan et al. 2006). Routine screening of women by health care professionals means routine inquiry about IPV for all women and adolescent girls during health care visits (Institute of Medicine Report, 2011). If practiced appropriately, this entails the health care professional asking the patient if she were abused using a validated instrument as part of history taking, confirming her abuse, assessing her safety, informing her of available resources, and making necessary referrals according to her wishes (Gerbert et al. 1999). A variety of screening tools for IPV are available but there is no consensus on which screening tool should be used or is most effective (Rabin et al. 2009). States have the authority to require and enforce policy around routine screening at the hospital level via protocols for identification of abuse (JCAHO, 1992) or by incorporating screening practices into licensing and training requirements of health care providers or facilities (Nudelman & Trias, 1999). Other policies that address IPV in health care settings include mandatory reporting of IPV to state authorities (e.g., police or state health departments) (Bledsoe et al. 2004), policies prohibiting insurance discrimination against IPV victims (Durborow et al. 2010), and policies forming state or local Domestic Violence Fatality Review Teams (Wilson & Websdale, 2006). Policy attention around routine screening for IPV has increased following the release of recommendations by the Institute of

Medicine (IOM) panel on women's preventive services and during the political debate surrounding re-authorization of VAWA during the 2012 federal legislative session.

New York and California, (1990 and 1995 respectively), were the first states to require all licensed hospitals and clinics to establish protocols to identify and intervene in IPV cases. These requirements were very similar in content to the 1992 Joint Commission guidelines (Nudelman & Trias, 1999). In addition, the 1995 California legislation required domestic violence coursework or training for the licensing and re-certification of health care providers (Nudelman & Trias, 1999). In 1998, Pennsylvania became the first state to establish a routine screening law entitled the Health Care Response Act (Governor's Family Violence Council, 2010). This law established a Domestic Violence Health Care Response Program in the Department of Welfare and provided for universal screening of patients under the medical advocacy projects funded through this legislation. Currently, 17 states ii have laws that require training of health care providers on domestic violence, with a great variation in requirements by state (Durborow et al. 2010). In addition, 12 states iii have enacted statutes requiring domestic violence protocols for health care facilities.

PROFESSIONAL ORGANIZATIONS AND ROUTINE IPV SCREENING RECOMMENDATIONS

A range of professional provider organizations, including physicians, nurses, and other clinicians, have issued guidelines that encourage routine IPV screening of patients by health care providers (American College of Obstetricians and Gynecologists, 1999; American College of Physicians, 1986; American Medical Association, 1992; American Nurses association, 1991). The American Medical Association states under its code of medical ethics E-2.02 (revised in 2007): "Physicians should routinely inquire about physical, sexual, and psychological abuse as part of the medical history." The American Congress of Obstetricians and Gynecologists (2012) has similar guidelines: "ACOG recommends that physicians screen ALL patients for intimate partner violence".

Several nursing associations also have endorsed routine screening for IPV in nursing practice. The American Nurses Association issued a Position statement on routine screening for IPV in 1991 (revised in 2000) that supports: "Universal, routine assessment and documentation of abuse for all women in any health care facility or community setting" (Charron et al. 2007, p. 6). A similar position statement was issued by the Emergency Nurses Association in 1994 and revised in 2006: "Emergency nurses are in a unique position to assess and detect actual and potential cases of abuse.... Universal screening and identification of victims of domestic violence is the first step to patient advocacy." Similarly, The Association of Women's Health, Obstetric and Neonatal Nurses AWHONN (2006) also maintained that: "All health care professionals should implement universal screening

ⁱⁱStates that require training on domestic violence include: AK, CA, CO, CT, FL, KY, MN, NH, NJ, NY, OH, OK, PA, SC, TN, WA, WV.

ⁱⁱⁱStates that require domestic violence protocols for health care facilities include: AK, CA, IL, IA, KY, NH, NY, OH, OK, PA, TX, WV.

protocols, documentation procedures, and treatment/intervention protocols in their health care settings to help identify and care for abused women”.

THE STATE OF THE EVIDENCE BASE FOR ROUTINE SCREENING

USPSTF Review and Recommendation

In 2004, the United States Preventive Services Task Force (USPSTF) “found insufficient evidence to recommend for or against routine screening of...women for intimate partner violence...” (USPSTF, 2004, p. 156). To reach this conclusion, the USPSTF used five criteria: 1) harm reduction resulting from screening, 2) identification of risk based on screening, 3) adverse effects of screening, 4) effectiveness of treatment interventions, and 5) the adverse effects of treatment interventions (Nelson, Nygren, & McInerney, 2004). Based on the evidence in these five areas, the USPSTF cited three main reasons for their decision: lack of screening tool accuracy for identifying IPV; limited studies assessing whether interventions reduce harm to women; and no studies assessing the harms of screening and interventions (Nelson et al. 2004).

Strengths of the Evidence Base

According to Russell (1994), the effectiveness of screening is assessed using the following five criteria: 1) a problem with high prevalence; 2) negative consequences on life expectancy and/or quality of life; 3) evidence of the increased effectiveness of early treatment; 4) a screening test with proven accuracy; the impact of this test on the patient must be more positive than negative; and 5) the treatment/intervention should be proven less harmful than the disease. (McAlpine & Wilson, 2004; Russell, 1994) As previously mentioned, IPV has a high prevalence and vast negative health consequences on abused women including death and more importantly, declared a public health issue since 1985. Thus, the first two criteria have been well documented in the literature. However, weaknesses in the evidence base lie in Russell’s remaining three criteria, which are congruent with USPSTF’s three main reasons for their 2004 decision.

Weaknesses of the Evidence Base

The third criterion of an effective screening policy is evidence of the increased effectiveness of early treatment. This criterion addresses USPSTF’s (2004, p. 156) third reason for their recommendation- “limited evidence as to whether interventions reduce harm to women.” The USPSTF (2004) only found two studies that satisfied its selection criteria. A longitudinal study that randomized 329 abused pregnant Hispanic women to three types of interventions- a brief one, counseling, and outreach- found after following them up at 2, 6, 12, and 18 months after delivery that severity of abuse decreases significantly over time for all groups but there were no statistically significant difference among the three groups (McFarlane et al. 2000). Another randomized controlled trial of an ethnically stratified sample of abused pregnant women (from public clinics in Texas and Virginia) who received counseling, education, and advocacy reported less violence at 6 and 12 months post-intervention compared to the comparison group who only received a card with information on resources available in their community but the differences were not statistically

significant (Parker et al. 1999). Moreover, the USPSTF (2004) concluded that these two studies are of limited generalizability since they mainly targeted pregnant women.

The fourth criterion of an effective screening policy is a “screening test with proven accuracy” and that the effects of this test on the patient have more benefits than harms. A number of long and brief instruments for screening women for IPV currently exist and have been found to have good psychometric qualities; (Attala et al. 1994; Hegarty et al. 1999; Shepard & Campbell, 1992; Brown et al. 1996; Feldhaus et al. 1997; Koziol-McLain et al. 2001). However, the USPSTF (2004, p. 156) cited that it “found no existing studies that determine the accuracy of screening tools for identifying family and intimate partner violence” as one of the key reasons for the recommendation. Their premise was that although, many abuse screening instruments have been developed and validated, they have not been directly validated against verified outcomes of abuse. In terms of the effects of routine screening, controversy exists whether routine screening increases victims’ safety; or jeopardizes safety (Warshaw, 1996; Durant et al. 2000). The USPSTF (2004, p.156) found “no direct evidence that screening for family and intimate partner violence leads to decreased disability and or premature death”. Moreover, it found no studies assessing the harms of screening. The fifth criterion of an effective screening policy states “the treatment/ intervention should be proven less harmful than the disease.” The USPSTF (2004) reported no studies assessing the harms of interventions that address IPV.

Two of the three key reasons for insufficient evidence for screening cited by the USPSTF (2004) recommendation will be challenged in an on-going randomized clinical trial funded by the Centers for Disease Control (it will not validate screening instruments for abuse), which will compare computerized screening and referral to advocacy services, using a “no screen no referral” control group and results are expected to be released in 2012 (Klevens & Saltzman, 2009). This clinical trial will evaluate the following outcomes one year after the intervention: mental health, disability, quality of life, and utilization of health care and IPV services.

Current State of the Evidence

More recently, there has been a growing consensus around recommending routine IPV screening. In a report published in May 2012 funded by AHRQ, Nelson and colleagues (2012) conducted a systematic review to update the 2004 U.S. Preventive Services Task Force Recommendation. They reviewed articles published between January 2002 and January 2012. A total of 36 studies addressed the USPSTF five questions resulting in “fair to good” overall quality rating. Based on this review, the USPSTF released a new draft recommendation statement that was available for comment from June 12 until July 10, 2012. The USPSTF (2012) “recommends that clinicians screen women of childbearing age for intimate partner violence (IPV), such as domestic violence, and provide or refer women who screen positive to intervention services”. The USPSTF (2012) cited the following reasons for its new B recommendation that favors screening: availability of screening instruments that can “identify current and past abuse or increased risk for abuse”, adequate evidence of reduction of harm using effective interventions, and that the adverse effects from screening or interventions are “no greater than small”. Table 1 compares the quality of the evidence in

the 2004 USPSTF recommendations to that in the 2012 draft recommendations according to the five criteria utilized by the USPSTF.

QUESTIONS THAT GUIDE POLICY DECISIONS

While there is growing consensus around the recommendation to adopt routine screening policies (by the USPSTF, IOM, and professional organizations), practical and logistic questions of specific screening strategies to be used, local resources and constraints, and implementation challenges remain for policymakers to consider and confront. Proponents of routine screening argue that routine screening increases victims' safety (Warshaw, 1996; Durant et al. 2000); whereas others contend it jeopardizes women's safety. Along these lines, Taft (2002) argues that before implementing routine screening, it is necessary to make sure of the health care system's ability to respond effectively to a woman's disclosure of abuse. He argues that poor responses can jeopardize women's safety and can lead to re-victimisation, 12tigmatization or feelings of hopelessness (Taft, 2002).

As clinicians must rely on evidence, expertise, and balance a range of considerations when providing care to their patients, policymakers must follow a similar process when undertaking decisions regarding health care policy. The challenge of policy making is particularly salient when the following conditions are met: 1) the evidence base is weak or the evidence regarding the effectiveness of a particular intervention is in dispute, 2) there is significant ethical or moral debate regarding the personal consequences and societal implications of policymaking around an issue. Both of these conditions are met as policymakers in state legislatures, departments of health, public and private health insurers and clinical settings struggle to identify appropriate policies to address the public health problem of IPV.

This debate has intensified following the apparent conflict between 2004 USPSTF recommendations and 2011 IOM recommendations, in the wake of political controversy surrounding the reauthorization of VAWA in 2012, and more recently, the USPSTF 2012 draft recommendation. In this context, policymakers face a challenge in disentangling evidence from values; both are important, but the distinction is critical to effectiveness and clarity in enacting and implementing health care policy. Below we offer a perspective on policymaking to address IPV, based on the framework set forth by Atkins, Siegel, and Slutsky in 2005 for evaluating debates about evidence in a policymaking context (Atkins, Siegel, & Slutsky, 2005).

What are the Public Health Goals of a Potential Screening Policy to Address IPV?

Political debates and values can obscure the main public health objectives of a health policy (Sommer, 2001) and before entering into a policy discussion about the merits or drawbacks or appropriateness of IPV screening in health care settings, the goal must be clear. For example, is the purpose of routine screening policy to detect IPV and make necessary referrals or is it to directly intervene? Policymakers should define these goals within their own context, bearing in mind the starting point, available resources, jurisdiction of the particular entity, and important stakeholders (i.e., physicians, nurses, hospitals, abused women, etc.). It is also important to prioritize outcomes based on importance and

achievability and to identify target populations for which the policy would have particular salience. For example, should the screening policy target high risk women such as pregnant or immigrant women or should it target all adolescent and adult women? Cost implications and practical imperatives should be considered upfront and used to frame the goals and objectives of policy; excluding these considerations may doom a policy to failure. (Atkins, Siegel, & Slutsky, 2005) It is often useful to employ a framework that outlines the inputs, outputs, processes, and outcomes envisioned as contributing to the accomplishment of the goals identified. Then, in the next stage, each assumption or connection could be examined in the context of available evidence and the opportunities and resources available to the policymaker who is seeking to make change. While the USPSTF makes recommendations for clinicians and policymakers by presenting state of the scientific evidence, they leave the details of implementation and other considerations such as cost-effectiveness, availability of resources, ethical and legal issues, and so forth to the discretion of clinicians and policymakers (Harris et al. 2001).

What is the Evidence Regarding Whether Screening Works?

Most policymakers are not researchers or statisticians; discerning the policy implications of a broad and varied research literature requires systematic review and evaluation regarding an intervention's efficacy, both in general and in a particular setting. Haynes (1999) succinctly stated the key policy-relevant questions for assessing health interventions: Can it work? Will it work? Is it worth it?

There are two important steps in the consumption of research by policymakers for the purposes of understanding whether an intervention could work. First, there must be evidence, and its quality must be considered when evaluating its relevance for policymaking. Too often, health policy research is plagued by problems of inadequate design or inappropriate interpretation, and findings must be interpreted in the context of the quality and strength of the study design employed (Majumdar & Soumerai, 2009). Fortunately, systematic reviews conducted by entities including the Cochrane Collaborative, the Evidence-Based Practice Centers supported by the Agency for Healthcare Research and Quality, and the USPSTF, help policymakers to make these distinctions. Secondly, once evidence is available and evaluated, there are a variety of ways in which it may be sought (or stumbled upon) and used in policymaking (Gold, 2009). The more deliberate and careful the process of information-gathering, the better-informed the policy decision is.

The USPSTF (2004) and IOM (2011) reports come to different conclusions regarding their recommendations for routine IPV screening, but both support the possibility that IPV screening can work. They differ in the relative weight placed on the latter two questions suggested by Haynes (1999). However, if the new draft USPSTF recommendation becomes final, then the USPSTF will be in agreement with the IOM in regards to those two questions. We believe that these questions ought to be examined in the setting (e.g., the specific state) in which policy implementation is being proposed or considered.

Will IPV Screening Work in My Policy Setting?

After having established the possibility that IPV screening might indeed effectively reduce the public health burden suffered by victims, as measured by specific health outcomes identified in the goal-setting described above, policymakers must assess the available evidence in the context of whether and how the proposed intervention could be effectively implemented in their particular setting. This includes consideration of the logistics of implementation, absorptive capacity, training and human capital, measurement, evaluation, enforcement, and – importantly – overcoming socio-cultural obstacles. A stakeholder analysis and engagement process may facilitate interpretation of efficacy data in a particular context and aid in the identification of unforeseen barriers or resources that would facilitate or hinder effectiveness (Varvasovskzy & Brugha, 2000).

If it would Work, How Do Harms and Benefits Compare in My Policy Setting?

Whether there is potential benefit to an IPV screening intervention in a particular policy setting is a necessary but not sufficient criterion. Policymakers must go beyond this to assess whether the benefits outweigh the financial, social, clinical, and opportunity costs. When considering whether a policy intervention would be “worth it,” it is important to examine the specific outcomes that may be affected, the size of potential benefits and harms, and the degree of uncertainty around these estimates (Atkins, Siegel, & Slutsky, 2005). This is where evidence meets values and where policy decisions become less straightforward and more explicitly tailored to a particular policymaker and that individual’s setting. Whether the evidence is “good enough” to suggest action or a policymaker deems it worthwhile to pursue something other than the status quo is entirely dependent on the value placed on benefits and harms. This is where the IOM and USPSTF differed in their estimation of what constitutes evidence strong enough to justify recommending a particular action and where the new USPSTF recommendation if confirmed would signify that the evidence is indeed “good enough” for action.

It is worth noting that policymaking offers the opportunity to empirically test the impacts of a policy decision and to make changes by carefully planning an evaluation component of policy implementation, including the collection of baseline data and quantifying the potential impacts of establishing a policy that turns out to be either effective or ineffective. Walking the line between acting too soon and delaying the implementation of a potentially beneficial strategy in order to collect more evidence is a challenging one for policy makers. This is especially true during times of massive transformation and reform in the health sector alongside a crippling economic recession and state budgetary pressures. Because the stakes are high for states and for individuals who suffer IPV, making careful, deliberate policy decisions is even more important.

IMPLICATIONS FOR POLICYMAKING

As policymakers consider how to incorporate the IOM 2011 guidelines, the existing (2004) and draft updated (2012) USPSTF recommendations, and the growing professional consensus on around routine IPV screening, in their own settings, there are implications for a range of policy issues: training and education, strategies for incorporating screening into

licensure requirements, mandating protocols in healthcare facilities, compliance, and funding issues.

Training and Education

The scarcity of training and education in the area of IPV as reported by the Committee on the Training Needs of Health Professionals to respond to family violence, which published a comprehensive review of medical and nursing curricula in 2002 (IOM, 2002) is one of the important barriers to routine IPV screening by physicians and nurses. In a recent systematic review of the literature on barriers to screening, training and education were of the most frequently mentioned resource barriers to screening among health care providers (Sprague, Madden, & Simunovic, 2012). The American Medical Association states as part of its code of medical ethics E-2.02 (revised in 2007): “Comprehensive training in matters pertaining to violence and abuse should be required in medical school curricula and in postgraduate training programs”. One way in which state policymakers can encourage training and education on the importance of screening for IPV is through incorporating screening into licensure requirements.

Incorporating Screening into Licensure Requirements

Through either legislative or executive action, it is possible for states to require IPV education and training to be incorporated into medical and nursing school curriculums, through licensure requirements. For example, state licensure exams for physicians, registered nurses, and licensed practical nurses could be amended to include questions about IPV related knowledge. Moreover, licensure requirements can consist of demonstrating satisfactory completion of a specified medical curriculum, which includes among other subjects, IPV education and training [e.g., California state licensure requirements (Durborow et al. 2010)]. States can also require the divisions of licensing of medical and nursing boards to consider adding to their list of continuing education requirements, courses that provide training and guidelines on how to conduct routine screening of IPV. They can also require these boards to periodically develop and disseminate information and education material on routine screening to health care providers and facilities. Durborow et al. (2010) provide a comprehensive account of how some states have incorporated IPV into their licensure and continuing education requirements.

Mandating Protocols in Healthcare Facilities

Similar to the protocols required by The Joint Commission’s accreditation standards, states can require – again, either through legislative or executive actions, depending on jurisdiction – all licensed health care facilities to develop protocols that include policies and procedures regarding IPV screening and intervention, ongoing training programs on IPV for all employees, provision for designated staff members to coordinate services to victims, and establishment of linkages with community IPV providers that could provide services to victims (see Durborow et al. 2010 for specific state laws). In order to deter health care facilities from not sustaining the protocols they implemented, states may consider a requirement for those facilities to conduct routine evaluations or report on the effectiveness of their protocols. This type of policy may address both the training needs of medical staff and provides institutional supports. Enforcement of this law requires routinely monitoring

licensed hospitals and clinics for following these protocols and including penalties for healthcare facilities that do not comply.

Compliance Issues

States need to come up with policies that foster compliance and higher screening rates by providers. IPV studies have found staff education alone insufficient in increasing screening rates among providers (Waalén et al. 2000, Fanslow et al. 1998). On the other hand, programs that utilize specific screening questions in addition to education have been associated with increased IPV screening, especially when prompts were utilized (Harwell et al. 1998, Wiist and McFarlane, 1999). Olson et al. (1996) found that adding a screening prompt, an additional question to the patient's chart in an emergency department, "Is the patient a victim of domestic violence?" resulted in significant increases in screening rates. A study that examined interventions used by physicians with screening expertise revealed an interesting suggestion to conquer the time constraint experienced by healthcare providers. This entailed using a team approach along with nurses, where they can refer the abused woman once identified directly to a nurse who counsels her and conducts follow-up (Gerbert et al. 1999). Implementing written policies and protocols in healthcare facilities has been found to significantly increase rates of screening and intervention with abuse victims (Waalén, et al. 2000). McLeer and Anwar (1989) found that following implementation of a screening protocol in an emergency department, abuse identification rates increased about 6-fold. Although education, alone, does not significantly increase screening, the research of McLeer et al. (1989) and McGrath et al. (1997) caution that for protocols to be effective, staff education and training are needed. Based on the fact that education and training alone cannot significantly increase screening rates, states may want to not only incorporate screening into licensing requirements of physicians and nurses, but also mandate IPV screening protocols in all licensed health care facilities.

Funding

Ensuring compliance with IPV screening recommendations requires that states, clinicians, and health care facilities have the resources they need to implement and enforce policies. Funding shortfalls could be a substantial obstacle to effective implementation of policies mandating health care facilities to adopt protocols that include training, assessment and intervention in IPV cases. Should policymakers decide to adopt such an option, they would be well-served to address resource issues upfront and may want to consider specific appropriations or funding mechanisms to support adoption and implementation of screening protocols and associated training, implementation, and enforcement requirements. Some potential funding sources states can utilize include local revenues from cigarette taxes or assessments charged against the batterers themselves through the criminal justice system. Some funding could be utilized from maternal and child health block grants and training help could be fostered from volunteers in IPV advocacy organizations. The state department of health can provide resources for education and training of providers in county health departments. Moreover, embedding IPV programs into existing public health programs such as reproductive health programs might be an option for some health care facilities such as county health departments which are bound by contracts with state departments of health.

CONCLUSION

Research on routine screening for IPV has made important strides since the USPSTF 2004 recommendations were released. However, efforts to strengthen the evidence base on the benefits and harms of routine screening and interventions for IPV should continue. These studies should utilize appropriate control groups, large sample sizes, more diverse and generalizable samples of women (i.e, not just pregnant or other high risk samples of women), and longitudinal designs that follow up women for long periods of time to verify long term outcomes.

Policymakers and clinicians should work with researchers to keep apprised of this developing evidence base and make their own judgments about whether and how routine screening may be implemented or improved their states or clinical practices. Moreover, while clinicians can contribute to the emerging evidence base through supporting clinical trials in their settings, policymakers can take steps to facilitate data collection, support local needs assessments, and make informed decisions regarding specific policies based on scientific evidence as well as feasibility in their specific policy settings (e.g. states and localities). Currently, there is limited research on which patient populations would benefit most from screening, how often screening should take place, and if screening should be conducted across specialties or only by primary care providers and obstetricians and gynecologists. This type of research would be especially beneficial for states, localities, and health care facilities with limited resources. Along the same line, future research should measure the cost-effectiveness of different screening methods, identify the specific settings that are most successful in identifying abused women and compare different interventions and identify those that are most effective in increasing women's safety and reducing IPV.

Given the recurrence of IPV, its negative health consequences on women and the growing consensus around routine screening for IPV, policymakers ought to consider the particular challenges and opportunities for addressing IPV in their states and formulate a policy strategy that enhances the capacity of the health care system to identify and appropriately treat those who suffer IPV.

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Table 1

Comparison of strength of the evidence between the 2004 USPSTF Recommendations and the 2012 USPSTF Draft Recommendations

USPSTF Criteria	Strength of the evidence	
	2004 USPSTF Recommendations	2012 USPSTF Draft Recommendations
Harm reduction resulting from screening	Did not find direct evidence that screening for IPV decreases disability or premature death	One fair quality trial (41–43% loss-to-follow up) that compared screening for IPV to usual care found better IPV and health outcomes for both groups 18 months later but no statistically significant different outcomes (MacMillan et al. 2009)
Identification of risk based on screening	Did not find any studies that validate screening instruments for IPV against verified outcomes of abuse.	The review found 6 screening instruments with high diagnostic accuracy: The 4-item Hurt, Insult, Threaten and Scream (Chen et al. 2005); The Ongoing Violence Assessment Tool (Ernst et al. 2004); The Slapped, Threatened, and Throw instrument (Paranjape and Liebschutz 2003); The Humiliation, Afraid, Rape, Kick instrument (Sohal, Eldridge, and Feder 2007); the Woman Abuse Screening Tool (Wathen, Jamieson, and MacMillan 2008); and the modified Childhood Trauma Questionnaire-Short Form (Thombs et al. 2007)
Adverse effects of screening	Did not find any studies that directly assess the harms of screening for IPV	One Canadian trial of 6743 women that compared adverse effects of screening to those of nonscreening in multiple sites (primary care, acute care, and Obstetrics & Gynecology sites) found no adverse effects of screening using the Consequences of Screening Tool (MacMillan et al. 2009).
Effectiveness of treatment interventions	Two fair-quality studies of interventions to reduce IPV among pregnant women (McFarlane et al. 2000; Parker et al. 1999) showed reduction in violence after brief counseling or outreach interventions, but findings were statistically nonsignificant (neither study included a non-intervention control group)	Six intervention trials, 3 targeted to pregnant and postpartum women and 3 enrolled women regardless of pregnancy status, met the USPSTF inclusion criteria. One trial was rated good quality (Kiely et al. 2010), four were rated fair (Bair-Merritt et al. 2010; McFarlane et al. 2006; Miller et al. 2011; Taft et al. 2011), and one was rated poor (Curry et al. 2006). Overall, counseling interventions resulted in decreased IPV, improved birth outcomes for pregnant women, reduced pregnancy coercion, and discontinuation of unsafe relationships
Adverse effects of treatment interventions	Did not find any studies that directly assess the harms of interventions for IPV	One 3-year trial (N=685) compared a home visitation intervention for mothers of at risk-newborns to a usual care control group and found that verbal abuse victimization and perpetration increased in the intervention group compared to the control group at long term follow-up, but the differences were not statistically significant (Bair-Merritt et al. 2010). Another trial that randomized 360 women to two groups: one that received a wallet-sized referral card and another that received 20-minute nurse management protocol, did not find any adverse effects of the intervention (McFarlane et al. 2006).